Release of dental records TO

Young Kidz Dental & Todd Young, DDS

I, _____,

(PARENT/GUARDIAN)

authorize the staff of _____

(PREVIOUS DENTAL OFFICE)

to release dental records for my child(ren):

_____

(PATIENT'S NAMES/DOB)

To: Young Kidz Dental

14210 SE Sunnyside Road #100

Clackamas, Oregon 97015

503-653-3384 info@youngkidzdental.com

Please release copies of:

_____ Current Dental x-rays

_____ Treatment History

Reason for transferring_____

_____

Printed Name: _____Date: _____

Signature: _____

(PARENT/GUARDIAN)